Retiree Benefits Enrollment & Reference Guide 2019

Effective July 1, 2019–June 30, 2020

HARFORD COUNTY GOVERNMENTAL ENTITIES

Contents

The purpose of this Enrollment and Reference Guide is to provide information about your benefits options and how to enroll for coverage or make changes to existing coverage. This Guide is only a summary of your choices and does not fully describe each benefit option. Please refer to your Employee Benefit Guide or Certificate of Coverage for information about the plans.

Every effort has been made to ensure that the information in this Guide is accurate; however, the provisions of the actual contracts for each plan will govern in the event of any discrepancy.

Benefits and Eligibility

Eligibility

Dependents*

Eligible family members include your:

- Legal spouse
- Dependent children until the end of the month in which they reach age 26
- Unmarried dependent children over the age limit if:
  - They are dependent on you for primary financial support and maintenance due to a physical or mental disability,
  - They are incapable of self-support, and
  - The disability existed before reaching age 26 or while covered under the plan.

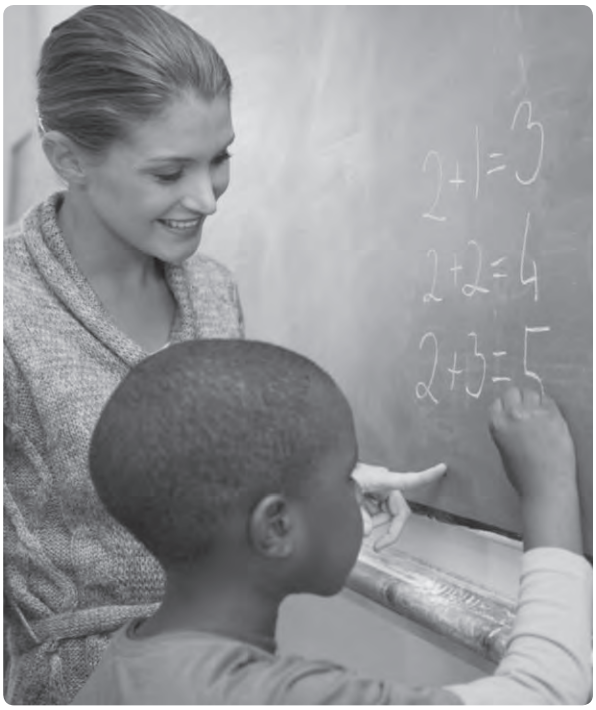
Eligible children include your:

- Natural children
- Stepchildren
- Legally adopted children
- Foster children
- A child for whom you have legal guardianship including grandchildren
- Child for whom the court has issued a QMSCO (Qualified Medical Child Support Order)

Ineligibility

Any ineligible dependents should be removed from your coverage as soon as they become ineligible. As a reminder we have included a few examples of ineligible dependents:

- Anyone who is not your legal spouse (ex-spouse, fiancé, common-law spouse, etc.)
- Dependents no longer covered by a court order
- Live-in partners
- Children of live-in partners
- Stepchildren following divorce from natural parent
- Parents of employees



* **You must submit life event changes within 30 days of event and verification of eligibility for all dependents on your account within 30 days of enrollment.**

Dependent Eligibility Documentation Requirements		
Relationship to Employee	**Eligibility Definition**	**Documentation for Verification of Relationship**
Spouse	A person to whom you are legally married	▪ **Copy of last year's Federal Tax Return** with the financial information crossed out. The tax form should be signed or submitted with proof of electronic filing **OR** ▪ **Proof of Current Joint Owership.** Document must be dated within the last six months and include the employee's name, spouse's name and current address. Acceptable documents include: ▪ Mortgage statement or renntal/lease agreement (financial information crossed out) ▪ Property tax bill (financial information crossed out) ▪ Joint checking or savings account statement (financial information crossed out)
Dependent Child(ren)	Dependent children until the end of the month in which they reach age 26	▪ **Natural Child—**Provide 1 of the following: ▪ Copy of birth certificate showing employee's name **OR** ▪ Hospital verification of birth (must include child's name, date of birth and parents' names) **OR** ▪ Certificate of birth ▪ **Step Child—**Provide 1 of the above showing employee's spouse name; and a copy of marriage certificate showing the employee and parent's name ▪ **Legal Guardian, Adoption, Grandchild(ren), or Foster Child(ren)—**Copy of Final Court Ordered Custody with presiding judge's signature and seal, or Adoption Final Decree with presiding judge's signature and seal. ▪ **Child for whom the court has issued a QMSCO—**A copy of the Qualified Medical Child Support Order
Disabled Dependents	Unmarried dependent children over the age limit if: 1. They are dependent on you for primary financial support and maintenance due to a physical or mental disability, 2. They are incapable of self-support, and 3. The disability existed before reaching age 26 or while covered under the plan.	▪ Copy of Social Security disability award (if a disability ruling by Social Security is pending, include a current copy of the application for disability) **AND** ▪ Federal Tax Return for year just filed **AND** ▪ Completed Disability Form (Request from Benefits Office)

Patient-Centered Medical Home

Supporting the relationship between you and your doctor

Whether you're trying to get healthy or stay healthy, you need the best care. That's why CareFirst[1] created the Patient-Centered Medical Home (PCMH) program to focus on the relationship between you and your primary care provider (PCP).

The program is designed to provide your PCP with a more complete view of your health needs. Your PCP will be able to use information to better manage and coordinate your care with all your health care providers including specialists, labs, pharmacies and others to ensure you get access to, and receive the most appropriate care in the most affordable settings.

Extra care for certain health conditions

If you have certain health conditions, your PCMH PCP will partner with a care coordinator, a registered nurse, to:

- Create a care plan based on your health needs with specific follow up activities
- Review your medications and possible drug interactions
- Check in with you to make sure you're following your treatment plan
- Assist you in obtaining services and equipment necessary to manage your health condition(s)

A PCP is important to your health

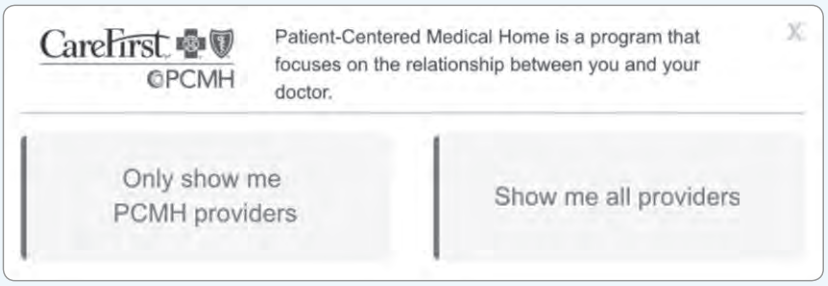
By visiting your PCP for routine visits, you build a relationship, and your PCP will get to know you and your medical history.

If you have an urgent health issue, having a PCP who knows your history often makes it easier and faster to get the care you need.

Even if you are young and healthy, or don't visit the doctor often, choosing a PCP is key to maintaining good health.

PCPs play a huge role in keeping you healthy for the long run. If you don't already have a relationship with a doctor, you can begin researching one today!

- To find a PCMH PCP, look for the PCMH logo when searching for primary care providers in our Provider Directory or log in to *My Account* and click *Select/Change PCP* under *Quick Links.*



[1] All references to CareFirst refer to CareFirst BlueCross BlueShield and CareFirst, BlueChoice, Inc., collectively.

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Triple Option Open Access

Available only to out-of-state residents

Triple Option Open Access offers you the freedom to visit any provider you wish. You have the flexibility to choose from both in- and out-of-network providers with your out-of-pocket costs determined by your choice. There is no need to choose a primary care provider (PCP) or to obtain a referral before visiting a specialist.

Benefits of the Triple Option Open Access Plan

- The ability to visit providers from either our BlueChoice Network, National PPO Network or out-of-area providers
- No PCP referral required to see a specialist
- Receive coverage for preventive health care services at no cost
- Take your health care benefits with you—across the country and around the world

How your plan works

With the Triple Option Open Access plan, you can visit any provider of your choosing. Your out-of-pocket costs are determined by who you decide to see.

In-network benefits provide a higher level of coverage, meaning you have lower out-of-pocket costs. Out-of-network benefits provide a lower level of coverage in exchange for the freedom to seek care from any provider you choose.

Your in- and out-of-network benefits are organized into three levels of coverage.

Level 1: For your lowest and most predictable in-network out-of-pocket costs, choose a BlueChoice provider. You can visit any of the 37,000 BlueChoice providers within Maryland, Washington, D.C. and Northern Virginia. Visit our online provider directory at **carefirst.com/doctor** to locate in-network providers.

Remember, you have direct access to CareFirst BlueChoice specialists without needing to obtain a referral from your PCP.

Level 2: To receive level 2 in-network benefits, visit a provider who participates in the national BlueCard® PPO network of over 600,000 doctors and 61,000 hospitals.

To identify an in-network CareFirst PPO provider, visit **carefirst.com/doctor**. To find a national BlueCard provider, visit the national provider directory at **provider.bcbs.com**.

Level 3: This level of coverage is out-of-network and offers you the most flexibility. In exchange for a lower level of coverage, you have the freedom to seek care from any provider you choose.

If you receive services from a provider who does not participate in any of the networks listed above, you may have to:

- Pay the provider's actual charge at the time you receive care
- File a claim for reimbursement
- Satisfy a higher deductible and/or coinsurance amount

In general, out-of-network providers do not have an agreement with CareFirst to accept the allowed benefit as payment in full for their services. Therefore, if you receive services from a non-participating provider, you may be balance billed based on the provider's actual charge.

Certain services under this level of coverage require you to meet a deductible. Check your benefits enrollment guide for details. When applicable, you are responsible for the entire cost of your medical care up to the amount of your deductible. Once your deductible is satisfied, your coverage will become available. Depending on the service, you may have to pay a copay or coinsurance when you receive care.

Hospital authorization

In-network providers will obtain any necessary admission authorizations for in-area (Maryland, Washington, D.C. and Northern VA). You will be responsible for obtaining authorization for services provided by out-of-network and out-of-area admissions. Call toll-free 888-PRE-AUTH (773-2884).

Inpatient Hospital Stay Claim					
Provider Status/Benefit Level	**Amount Charged**	**Allowed Benefit**	**CareFirst BlueCross BlueShield Pays**	**Member Pays**	
BlueChoice/Level 1	$14,800	$8,160	$7,344	$816	10% AB
PPO/Level 2	$14,800	$9,180	$8,262	$918	10% AB
Participating*/Level 3	$14,800	$10,200	$6,640	$3,560	$500 deductible then 30% AB
Non-participating*/Level 3	$14,800	$10,200	$6,640	$8,160	$500 deductible then 30% AB ($3,560 + balance to charge $4,600)
Primary Care Provider Office Visit					
Provider Status/Benefit Level	**Amount Charged**	**Allowed Benefit**	**CareFirst BlueCross BlueShield Pays**	**Member Pays**	
BlueChoice/Level 1	$150	$64	$57.60	$6.40	10% AB
PPO/Level 2	$150	$72	$64.80	$7.20	10% AB
Participating*/Level 3	$150	$80	$0	$80	Deductible applied
Non-participating*/Level 3	$150	$80	$0	$150	$80 deductible plus balance to charge $70
Maternity Provider Delivery Charge					
Provider Status/Benefit Level	**Amount Charged**	**Allowed Benefit**	**CareFirst BlueCross BlueShield Pays**	**Member Pays**	
BlueChoice/Level 1	$5,864	$3,616	$3,254.40 (90% AB)	$361.60	10% AB
PPO/Level 2	$5,864	$4,068	$3,661.20 (90% AB)	$406.80	10% AB
Participating*/Level 3	$5,864	$4,520	$3,164	$1,356	Deductible was already met 30% AB
Non-participating*/Level 3	$5,864	$4,520	$3,164	$2,700	Deductible was met 30% AB $1,356 + difference to charge $1,344

BlueCard & Global Core

Wherever you go, your health care coverage goes with you

With your Blue Cross and Blue Shield member ID card, you have access to doctors and hospitals almost anywhere. BlueCard gives you the peace of mind that you'll always have the care you need when you're away from home, from coast to coast. And with Blue Cross Blue Shield Global Core (Global Core) you have access to care outside of the U.S.

As always, go directly to the nearest hospital in an emergency.

Your membership gives you a world of choices. More than 93% of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield plans. Whether you need care here in the United States or abroad, you'll have access to health care in more than 190 countries.

When you're outside of the CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. service area (Maryland, Washington, D.C., and Northern Virginia), you'll have access to the local Blue Cross Blue Shield Plan and their negotiated rates with doctors and hospitals in that area. You shouldn't have to pay any amount above these negotiated rates. Also, you shouldn't have to complete a claim form or pay up front for your health care services, except for those out-of-pocket expenses (like non-covered services, deductibles, copayments, and coinsurance) that you'd pay anyway.

Within the U.S.

1. Always carry your current member ID card for easy reference and access to service.
2. To find names and addresses of nearby doctors and hospitals, visit the National Doctor and Hospital Finder at **www.bcbs.com**, or call BlueCard Access at 800-810-BLUE (2583).
3. Call Member Services for pre-certification or prior authorization, if necessary. Refer to the phone number on your ID card because it's different from the BlueCard Access number listed in Step 2.
4. When you arrive at the participating doctor's office or hospital, simply present your ID card.
5. After you receive care, you shouldn't have to complete any claim forms or have to pay up front for medical services other than the usual out-of-pocket expenses. CareFirst will send you a complete explanation of benefits.

Around the world

Like your passport, you should always carry your ID card when you travel or live outside the U.S. The BlueCard Worldwide program provides medical assistance services and access to doctors, hospitals and other health care professionals around the world. Follow the same process as if you were in the U.S. with the following exceptions:

- At hospitals in the Global Core Network, you shouldn't have to pay up front for inpatient care, in most cases. You're responsible for the usual out-of-pocket expenses. And, the hospital should submit your claim.
- At hospitals outside the Global Core Network, you pay the doctor or hospital for inpatient care, outpatient hospital care, and other medical services. Then, complete an international claim form and send it to the Global Core Service Center. The claim form is available online at **bcbs.globalcore.com**.
- To find a BlueCard provider outside of the U.S. visit **bcbs.com**, select *Find a Doctor or Hospital.*

Members of Maryland Small Group Reform (MSGR) groups have access to emergency coverage only outside of the U.S.

Medical assistance when outside the U.S.

Call 800-810-BLUE (2583) toll-free or 804-673-1177, 24 hours a day, 7 days a week for information on doctors, hospitals, other health care professionals or to receive medical assistance services. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a doctor or arrange hospitalization if necessary.

Visit **bcbs.com** to find providers within the U.S. and around the world.

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BlueChoice Opt-Out Plus Open Access

A plan with predictable costs and the freedom to choose

BlueChoice Opt-Out Plus Open Access offers in- and out-of-network coverage to help control your out-of-pocket costs and there's no referral to see a specialist. We also offer online tools and resources at **carefirst.com** that give you the flexibility to manage your health care and wellness goals wherever you are.

Take advantage of your benefits

- $0 cost for comprehensive preventive health care visits.
- Choose any provider—no referrals needed.
- A network of almost 40,000 CareFirst BlueChoice providers (PCPs, nurse practitioners, specialists, hospitals, pharmacies, and diagnostic centers) in Maryland, Washington, D.C. and Northern Virginia.
- After-hours care, including a free 24-hour nurse advice line, video visits, convenience care clinics and urgent care centers.
- If you need care outside the CareFirst BlueCross BlueShield (CareFirst) service area of Maryland, Washington, D.C. and Northern Virginia, you have access to thousands of providers in all 50 states and receive out-of-network benefits when you see a BlueCard® PPO provider.
- No balance billing when you visit a CareFirst BlueChoice or BlueCard® PPO provider.

Benefits at a glance

Preventive care and sick office visits

You are covered for all preventive care as well as sick office visits.

Large provider network

You can choose any doctor from our large network of providers. Our network also includes specialists, hospitals and pharmacies—giving you many options for your health care.

Specialist services

Your coverage includes services from specialists without a referral. Specialists are doctors or nurses who are highly trained to treat certain conditions, such as cardiologists or dermatologists.

Prescription drug coverage

Your plan covers prescription drugs.

Hospital services

You're covered for overnight hospital stays. You're also covered for outpatient services, those procedures you get in the hospital without spending the night. Your PCP or specialist must provide prior authorization for all inpatient hospital services and may need to provide prior authorization for some outpatient hospital services such as rehabilitative services, chemotherapy and infusion services.

Labs, X-rays or specialty imaging

Covered services include provider-ordered lab tests, X-rays and other specialty imaging tests (MRI, CT scan, PET scan, etc.).

Well-child visits

All well-child visits and immunizations are covered.

Maternity and pregnancy care

You are covered for doctor visits before and after your baby is born, including hospital stays. If needed, we also cover home visits after the baby's birth.

Mental health and substance use disorder

Your coverage includes behavioral health treatment, such as psychotherapy and counseling, mental and behavioral health inpatient services and substance use disorder treatment.

How your plan works

In-network benefits provide a higher level of coverage. This means you have lower out-of-pocket costs when you visit a participating CareFirst BlueChoice provider. However, the choice is entirely yours. That's the advantage of this plan.

Out-of-network benefits are also available. If you receive care outside of the BlueChoice network, you'll incur lower costs by using a participating national BlueCard PPO provider. Your benefits will be paid at the out-of-network level, but you will be protected from balance billing. To find a national participating provider, visit **carefirst.com/doctor**.

You still have the option to opt-out of this network and see a non-participating provider, but will be subject to higher out-of-pocket expenses and could be balanced billed.

If you receive services from a provider outside of the BlueChoice or national BlueCard PPO networks, you may have to:

- Pay the provider's actual charge at the time you receive care
- File a claim for reimbursement
- Satisfy a higher deductible and/or coinsurance amount

Hospital authorization

CareFirst BlueChoice providers will obtain any necessary admission authorizations for in-area covered services. You will be responsible for obtaining authorization for services provided by out-of-network providers and out-of-area admissions. Call toll-free at 866-PREAUTH (773-2884).

Prior authorization is not required for emergency admissions or maternity admissions.

Your benefits

Step 1: Select a PCP

Establishing a relationship with one doctor is the best way to receive consistent, quality health care. When you enroll in a BlueChoice HMO plan, you select a PCP—either a physician or nurse practitioner—to manage your primary medical care. Make sure you select a PCP for yourself and each of your covered family members. Your PCP must participate in the CareFirst BlueChoice provider network and must specialize in family practice, general practice, pediatrics or internal medicine.

To ensure that you receive the highest level of benefits and pay the lowest out-of-pocket costs for all services, see your PCP for preventive and routine care.

Step 2: Your plan will start to pay for services

Your full benefits will become available once your deductible (if applicable) is met. However, the level of those benefits will depend on whether you see in-network or out-of-network providers. Depending on your particular plan, you may also have to pay a coinsurance when you receive care.

You will have a different deductible amount for in-network versus out-of-network benefits and the in- and out-of-network medical deductibles contribute toward one another. For example, when you see in-network providers, your expenses will count toward both your in-network deductible and out-of-network deductible.

Deductible requirements vary based on whether your coverage is an individual or family plan. If more than one person is covered under your plan, please refer to your Evidence of Coverage for detailed information on deductibles.

Step 3: Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your benefit period. Any amount you pay toward your deductible (if applicable) and most copays and/or coinsurance will count toward your out-of-pocket maximum.

Just like your deductible, there are different in-network and out-of-network amounts and the in- and out-of-network out-of-pocket maximums contribute toward one another.

Please keep in mind that out-of-pocket requirements also differ if your coverage is an individual or family plan. Detailed information on out-of-pocket maximum amounts can be found in your Evidence of Coverage.

Labs, X-rays or specialty imaging

If you access laboratory services inside the CareFirst service area (Maryland, Washington, D.C. and Northern Virginia) you must use LabCorp as your lab test facility for in-network benefits. Services performed by any other provider, while inside the CareFirst service area, will be considered out-of-network. Also, any lab work performed in an outpatient hospital setting will require prior authorization from your PCP.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. To locate a LabCorp patient service center near you, call 888-LAB-CORP (522-2677) or visit **labcorp.com**.

If you access laboratory services outside of Maryland, D.C. or Northern Virginia, you may use any participating BlueCard PPO facility and receive out-of-network benefits. To find laboratory service providers outside of the CareFirst service area, visit our *Find a Provider* tool (**carefirst.com/doctor**) and search by *Labs*.

If you need X-rays or other specialty imaging services when inside the CareFirst service area, you must visit a participating freestanding/non-hospital diagnostic center such as Advanced Radiology. If you need X-rays or other specialty imaging services when outside the CareFirst service area, you may use any participating BlueCard PPO facility and receive out-of-network benefits.

Out-of-area coverage

You have the freedom to take your health care benefits with you. BlueCard PPO, a program from the Blue Cross and Blue Shield Association, allows you to receive health care benefits while traveling outside of the CareFirst service area (Maryland, Washington, D.C. and Northern Virginia). The BlueCard program includes more than 6,100 hospitals and 600,000 other health care providers nationally.

* This is not a complete list of all services. For a comprehensive explanation of your coverage, please check your Evidence of Coverage.

For urgent and emergency services received outside of the CareFirst service area, you will receive in-network benefits. All other services received outside of the service area will be at the out-of-network level.

Away From Home Care

In addition, members and their covered dependents planning to be out of the CareFirst BlueChoice, Inc. service area for at least 90 consecutive days may be able to take advantage of a special program, Away From Home Care®.

This program allows temporary benefits through another Blue Cross and Blue Shield affiliated HMO. It provides coverage for routine services and is perfect for extended out-of-town business or travel, semesters at school or families living apart.

For more information on Away From Home Care, please call Member Services at the phone number listed on the back of your ID card.

Global Coverage

If you travel outside of the U.S., access to quality medical coverage is essential to keeping you healthy and productive. With BlueCross BlueShield Global Core* solutions from CareFirst, you'll receive:

- Access to nearly 170,000 English-speaking providers and more than 11,500 hospitals in nearly 200 countries worldwide
- 24/7 telephone support
- Seamless claims processing/reimbursement designed for occasional or short-term travel, the Core plan connects members with their home plan benefits to provide basic medical coverage outside of the U.S.

For more information on Global Core, please call 800-810-BLUE (2583).

Important terms

ALLOWED BENEFIT: The maximum amount CareFirst approves for a covered service, regardless of what the doctor actually charges. Providers who participate in the CareFirst BlueChoice network cannot charge our members more than the allowed amount for any covered service.

BALANCE BILLING: Billing a member for the difference between the allowed charge and the actual charge.

COINSURANCE: The percentage of the allowed benefit you pay after you meet your deductible.

COPAY: A fixed-dollar amount you pay when you visit a doctor or other provider.

DEDUCTIBLE: The amount of money you must pay each year before your plan begins to pay its portion for the cost of care.

IN-NETWORK: Doctors, hospitals, labs and other providers or facilities that are part of the CareFirst BlueChoice network. Please refer to the *How your plan works* section for more information about in-network services in the CareFirst service area vs. out of the CareFirst service area.

OUT-OF-NETWORK: Doctors, hospitals, labs and other providers or facilities that do not participate in the CareFirst BlueChoice network. Please refer to the *How your plan works* section for more information about out-of-network services in the CareFirst service area vs. out of the CareFirst service area.

PRIMARY CARE PROVIDER (PCP): The doctor or medical professional you go to for primary care and who coordinates or arranges other services you need.

*BlueCross BlueShield Global is a brand owned by BlueCross BlueShield Association.

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BlueVision

A plan for healthy eyes, healthy lives

Professional vision services including routine eye examinations, eyeglasses and contact lenses offered by CareFirst BlueChoice, through the Davis Vision, Inc. national network of providers.

How the plan works

How do I find a provider?

To find a provider, go to **carefirst.com** and utilize the *Find a Provider* feature or call Davis Vision at **800-783-5602** for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

How do I receive care from a network provider?

Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueChoice member and provide the doctor with your identification number, as well as your date of birth. Then go to the provider to receive your service. There are no claim forms to file.

Can I get contacts and eyeglasses in the same benefit period?

With BlueVision, the benefit covers one pair of eyeglasses or a supply of contact lenses per benefit period at a discounted price[1].

Mail order replacement contact lenses

DavisVisionContacts.com offers members the flexibility to shop for replacement contact lenses online after benefits are spent. This website offers a wide array of contact lenses, easy, convenient purchasing online and quick shipping direct to your door.

Need more information? Visit **carefirst.com** or call 800-783-5602.

[1] As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.

Summary of Benefits

(12-month benefit period)

In-Network	You Pay
EYE EXAMINATIONS[1]	
Routine Eye Examination with dilation (per benefit period)	$10
FRAMES[1,2]	
Priced up to $70 retail	$40
Priced above $70 retail	$40, plus 90% of the amount over $70
SPECTACLE LENSES[2]	
Single Vision	$35
Bifocal	$55
Trifocal	$65
Lenticular	$110
LENS OPTIONS[2,3] *(add to spectacle lens prices above)*	
Standard Progressive Lenses	$75
Premium Progressive Lenses (Varilux®, etc.)	$125
Ultra Progressive Lenses (digital)	$140
Polarized Lenses	$75
High Index Lenses	$55
Glass Lenses	$18
Polycarbonate Lenses	$30
Blended invisible bifocals	$20
Intermediate Vision Lenses	$30
Photochromic Lenses	$35
Scratch-Resistant Coating	$20
Standard Anti-Reflective (AR) Coating	$45
Ultraviolet (UV) Coating	$15
Solid Tint	$10
Gradient Tint	$12
Plastic Photosensitive Lenses	$65
CONTACT LENSES[1,3]	
Contact Lens Evaluation and Fitting	85% of retail price
Conventional	80% of retail price
Disposable/Planned Replacement	90% of retail price
DavisVisionContacts.com Mail Order Contact Lens Replacement Online	Discounted prices
LASER VISION CORRECTION[3]	
Up to 25% off allowed amount or 5% off any advertised special[4]	

[1] At certain retail locations, members receive comparable value through their everyday low price on examination, frame and contact lens purchase.

[2] CareFirst BlueChoice does not underwrite lenses, frames and contact lenses in this program. This portion of the Plan is not an insurance product. As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.

[3] Special lens designs, materials, powers and frames may require additional cost.

[4] Some providers have flat fees that are equivalent to these discounts.

Exclusions
The following services are excluded from coverage:

1. Diagnostic services, except as listed in What's Covered under the Evidence of Coverage.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the Evidence of Coverage.
3. Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage or a rider or endorsement purchased by your Group and attached to the Evidence of Coverage.
4. Services or supplies not specifically approved by the Vision Care Designee where required in What's Covered under the Evidence of Coverage.
5. Orthoptics, vision training and low vision aids.
6. Glasses, sunglasses or contact lenses.
7. Vision Care services for cosmetic use.
8. Services obtained from Non-Contracting Providers.

For BlueChoice Opt-Out Plus members, Vision Care benefits are not available under the Out-of-Network Evidence of Coverage.

Exclusions apply to the Routine Eye Examination portion of your vision coverage. Discounts on materials such as glasses and contacts may still apply.

Benefits issued under policy form numbers: MD/BC-OOP/VISION (R. 6/04) • DC/BC-OOP/VISION (R. 6/04) • VA/BC-OOP/VISION (R. 6/04)

Away From Home Care®

Your HMO coverage goes with you

We've got you covered when you're away from home for 90 consecutive days or more. Whether you're out-of-town on extended business, traveling, or going to school out-of-state, you have access to routine and urgent care with our Away From Home Care program.

Coverage while you're away

You're covered when you see a provider of an affiliated Blue Cross Blue Shield HMO (Host HMO) outside of the CareFirst BlueChoice, Inc. service area (Maryland, Washington, D.C. and Northern Virginia). If you receive care, then you're considered a member of that Host HMO receiving the benefits under that plan. So your copays may be different than when you're in the CareFirst BlueChoice service area. You'll be responsible for any copays under that plan.

Enrolling in Away From Home Care

To make sure you and your covered dependents have ongoing access to care:

- Call the Member Service phone number on your ID card and ask for the Away From Home Care Coordinator.
- The coordinator will let you know the name of the Host HMO in the area. **If there are no participating affiliated HMOs in the area, the program will not be available to you.**
- The coordinator will help you choose a primary care physician (PCP) and complete the application. Once completed, the coordinator will send you the application to sign and date.
- Once the application is returned, we will send it to your Host HMO.

Always remember to carry your ID card to access Away From Home Care.

- The Host HMO will send you a new, temporary ID card which will identify your PCP and information on how to access your benefits while using Away From Home Care.
- Simply call your Host HMO primary care physician for an appointment when you need care.

No paperwork or upfront costs

Once you are enrolled in the program and receive care, you don't have to complete claim forms, so there is no paperwork. And you're only responsible for out-of-pocket expenses such as copays, deductibles, coinsurance and the cost of non-covered services.

BRC6389-1P (8/17)

Prescription Drug Program

A total prescription for health

Prescription drugs are an integral part of high-quality health care. The prescription benefits your employer is offering give you an affordable and convenient way to make the best decisions when it comes to your prescriptions.

Your prescription benefits

As a CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. (CareFirst) member, you'll have access to:

- A nationwide network of more than 69,000 participating pharmacies
- Nearly 5,000 covered drugs
- Mail Service Pharmacy, a convenient and fast option to refill your prescriptions through home delivery
- Coordinated medical and pharmacy programs to help improve your overall health and reduce costs

Keeping you informed

Together with our pharmacy benefit manager, CVS Caremark®,* we keep you informed about your prescription drug coverage and provide you with periodic updates about your plan through targeted mailings and phone calls. Take the call and/or review your mailed notices to learn about lower-cost drug alternatives, possible safety concerns, drug tier changes and more.

Online tools and resources

To get the most from your prescription drug plan, you need to stay informed. Our easy-to-use, interactive tools and resources are available 24/7. Visit **carefirst.com/rxgroup** to see if a drug is covered, find a pharmacy, learn how drugs interact with each other and get more information about medications. You can access even more tools and resources once you're a member through *My Account* by selecting *Drug and Pharmacy Resources* under *Quick Links.*

* CVS Caremark is an independent company that provides pharmacy benefit management services to CareFirst members.

3-Tier Risk

Understanding your formulary

A formulary is a list of covered prescription drugs. Our drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other health care professionals who make sure the drugs on the formulary are safe and clinically effective. The prescription drugs found on the CareFirst Formulary (drug list) are divided into tiers. These tiers include zero-dollar cost share, generics, preferred brand and non-preferred brand drugs. Your cost share is determined by the tier the drug falls into.

Drug tier	Description
Tier 0: $0 Drugs	▪ Preventive drugs (e.g. statins, aspirin, folic acid, fluoride, iron supplements, smoking cessation products and FDA-approved contraceptives for women) are available at a zero-dollar cost share if prescribed under certain medical criteria by your doctor.
Tier 1: Generic Drugs $	▪ Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. ▪ Generic drugs generally cost less than brand-name drugs.
Tier 2: Preferred Brand Drugs $$	▪ Preferred brand drugs are brand-name medications that do not have a generic equivalent. ▪ They are chosen for their cost-effectiveness to alternatives. ▪ Your cost share will be more than generic drugs but less than non-preferred brand drugs. ▪ If a generic drug becomes available, the preferred brand drug will be moved to the non-preferred brand tier.
Tier 3: Non-Preferred Brand Drugs $$$	▪ Non-preferred brand drugs often have a generic or preferred brand drug option where your cost share will be lower.

Note: If the cost of your drug is less than your copay or coinsurance, you only pay the cost of the drug. Once you meet your deductible (if applicable to your plan), you may pay a different copay or coinsurance for drugs depending on the drug tier. Some drugs may not be covered based on your plan. There is an exception process if you need an excluded drug to be covered for medical necessity reasons. Check your benefit summary or enrollment materials for specific plan information. Once you are a member, you can view specific cost-share information in *My Account.*

Preferred Drug List

CareFirst's Preferred Drug List includes generic and preferred brand drugs selected for their quality, effectiveness and safety by the CVS Caremark national Pharmacy and Therapeutics (P&T) committee. By using the CareFirst Preferred Drug List, you can work with your doctor or pharmacist to make safe and cost-effective decisions to better manage your health care and out-of-pocket costs.

Non-preferred drugs aren't included on the Preferred Drug List; they are still covered but at the highest cost share. Also, some drugs on the Preferred Drug List may not be covered based on your plan. To see your full formulary, go to **carefirst.com/rxgroup**.

Prescription guidelines

Some medications are only intended to be used in limited quantities; others require that your doctor obtain prior authorization through CareFirst before they can be filled. These drug guidelines are indicated on the formulary found at **carefirst.com/rxgroup**.

- **Quantity limits** have been placed on the use of selected drugs for quality or safety reasons. Limits may be placed on the amount of the drug covered per prescription or for a defined period of time.
- **Prior authorization** is required before you fill prescriptions for certain drugs. Your doctor must obtain approval from CareFirst before these drugs are covered.
- **Step therapy** asks that you try lower-cost, equally effective drugs that treat the same medical condition before trying a higher-cost alternative. Prior to getting the higher-cost alternative, your doctor must receive approval from CareFirst.

Two ways to fill

Retail pharmacies

With access to more than 69,000 pharmacies across the country, you can visit **carefirst.com/rxgroup** and use our *Find a Pharmacy* tool to locate a convenient participating pharmacy. Be sure to take your prescription and member ID card with you when filling prescriptions.

Mail Service Pharmacy

Mail Service Pharmacy is a convenient way to fill your prescriptions, especially for refilling drugs taken frequently. You can register three ways—online through *My Account*, by phone or by mail. Once you register for Mail Service Pharmacy you'll be able to:

- Refill prescriptions online, by phone or by email
- Choose your delivery location
- Consult with pharmacists by phone 24/7
- Schedule automatic refills
- Receive email notification of order status
- Choose from multiple payment options

Ways to save

Here are some ways to help you save on your prescription drug costs.

- **Use generic drugs**—generic drugs can cost up to 80 percent less than their brand-name counterparts. Made with the same active ingredients as their brand-name counterparts, generics are also equivalent in dosage, safety, strength, quality, performance and intended use.
- **Use drugs on the Preferred Drug List**—the Preferred Drug List identifies generic and preferred brand drugs that may save you money.
- **Use maintenance medications**—maintenance medications are drugs you take regularly for ongoing conditions such as diabetes, high blood pressure or asthma. You can get up to a three-month supply of your maintenance medications for the cost of two copays through any pharmacy in the network, including through mail order.
- **Use mail order**—by using our Mail Service Pharmacy you get the added convenience of having your prescriptions delivered right to your home. Plus, if you pay a coinsurance for your maintenance drugs, the overall cost of the drug may be less expensive through mail order, reducing your out-of-pocket costs.

Care management programs

Together with CVS Caremark, our pharmacy benefit manager, we offer care management programs and tools designed to improve your health while lowering your overall health care costs.

Specialty Pharmacy Coordination Program

The Specialty Pharmacy Coordination Program provides personalized care for our members with certain chronic conditions, like rheumatoid arthritis or cancer, requiring the use of specialty drugs. For certain chronic conditions, you will receive enhanced one-on-one support with a registered nurse and dedicated clinical team who will coordinate care with your doctor.

The program provides:

- 24-hour pharmacist assistance
- Injection training coordination
- Educational materials for your specific condition
- Drug interaction monitoring and review
- Drugs mailed to your home or office, or available for pick up at any CVS retail pharmacy
- Refill reminders

Comprehensive Medication Review

When you are taking multiple drugs to treat a medical condition, it can be overwhelming. The Comprehensive Medication Review program can connect you with a CVS Caremark pharmacist who will review your drugs and talk to your doctor about dosages, duration and any other pertinent issues. The pharmacist will work with your doctor to evaluate opportunities to:

- Identify possible drug interactions
- Improve drug adherence
- Reduce gaps in care
- Eliminate duplications in drug therapy

The program works with your doctor to ensure that you are not only taking the best drugs to manage your conditions, but you are also able to take your drugs as prescribed.

Medication Therapy Management Program

Taking medications as prescribed not only helps improve your health but can also reduce your health care costs. CareFirst's Medication Therapy Management program is designed to help you get the best results from your drug therapy.

We review pharmacy claims for opportunities to:

- Save you money
- Support compliance with medications
- Improve your care
- Ensure safe use of high-risk medications

When opportunities are identified, "Drug Advisories" will be communicated to either you and/or your doctor regarding your drug therapy. Through our Pharmacy Advisor program, you may also have the opportunity to speak one-to-one with a pharmacist, who can answer questions and help you manage your prescription drugs.

Should you have any questions about your prescription benefits, please contact CareFirst Pharmacy Services at 800-241-3371.

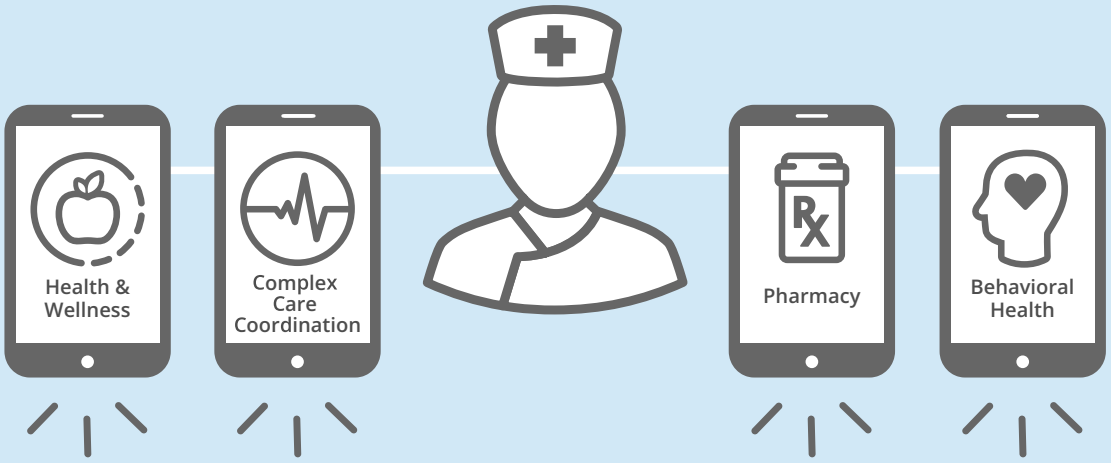
SUM1609-1P (9/17)

Take the Call

You know that CareFirst BlueCross BlueShield (CareFirst) provides your health benefits and processes claims, but that's not all we do. We're there for you at every step of care—and every stage, even when life throws you a curveball.

Whether you are faced with an unexpected medical emergency, managing a chronic condition like diabetes, or looking for help with a health goal such as losing weight, we offer one-on-one coaching and support programs. You may receive a letter or postcard in the mail, or a call from a nurse, health coach or pharmacy technician explaining the programs and inviting you to participate.

These programs are confidential and part of your medical benefit. They can also play a huge role in helping you through an illness or keeping you healthy. Once you decide to participate, you can choose how involved you want to be. We encourage you to connect with the CareFirst team so you can take advantage of this personal support.



CareFirst may call you to offer one-on-one support programs concerning Health & Wellness, Complex Care Coordination, Pharmacy or Behavioral Health

carefirst.com/takethecall

Take the Call

Here are a few examples of when we may contact you about these programs.
Visit **carefirst.com/takethecall** to learn more.

	Program name	Overview	Why it's important	Communication
	**Health & Wellness**	Personal coaching support to help you achieve your health goals	Health coaching can help you manage stress, eat healthier, quit smoking, lose weight and much more	Letter or phone call from a ***Sharecare coach***
	**Complex Care Coordination**	Support for a variety of critical health concerns or chronic conditions	Connecting you with a nurse who works closely with your primary care provider (PCP) to help you understand your doctor's recommendations, medications and treatment plans	Introduction by your PCP or a phone call from a ***CareFirst care coordinator (nurse)***
	**Hospital Transition of Care**	Supporting transition from hospital to home	Help plan for your recovery after you leave the hospital, answer your questions and, based on your needs, connect you to additional services	Onsite visit or phone call from a ***CareFirst nurse***
	**Pharmacy Advisor**	Managing medications for specific conditions	Understanding your condition and staying on track with appropriate medications is crucial to successfully managing your health	Letter or a phone call from a ***CVS Caremark pharmacy specialist***
	Comprehensive Medication Review	Managing multiple medications	Talking to a pharmacist who understands your medication history can help identify any possible side effects or harmful interactions	Phone call from a ***CVS Caremark pharmacist***
	Specialty Pharmacy Coordination	Managing specialty medications for chronic conditions	Connecting with a nurse who specializes in your condition provides additional support so you can adhere to your treatment plan for better health	Letter or phone call from a ***CVS Caremark specialty nurse***
	**Behavioral Health and Substance Use Disorder**	Support for mental health and/or addiction issues	Confidential, one-on-one support to help schedule appointments, explain treatment options, collaborate with doctors and identify additional resources	Phone call from a ***CareFirst behavioral health care coordinator***

This wellness program is administered by Sharecare, Inc., an independent company that provides health improvement management services to CareFirst members. Sharecare, Inc. does not provide CareFirst BlueCross BlueShield products or services and is solely responsible for the health improvement management services it provides.

CVS Caremark is an independent company that provides pharmacy benefit management services to CareFirst members. CVS Caremark does not provide CareFirst BlueCross BlueShield products or services and is solely responsible for the pharmacy benefit management services it provides.

SUM4110-1P (3/19)

Know Before You Go

Your money, your health, your decision

Choosing the right setting for your care—from allergies to X-rays—is key to getting the best treatment with the lowest out-of-pocket costs. It's important to understand your options so you can make the best decision when you or your family members need care.*

Primary care provider (PCP)

Establishing a relationship with a primary care provider is the best way to receive consistent, quality care. Except for emergencies, your PCP should be your first call when you require medical attention. Your PCP may be able to provide advice over the phone or fit you in for a visit right away.

FirstHelp—free 24-hour nurse advice line

Call 800-535-9700 anytime to speak with a registered nurse. Nurses can provide you with medical advice and recommend the most appropriate care.

CareFirst Video Visit

See a doctor 24/7 without an appointment! You can consult with a board-certified doctor on your smartphone, tablet or computer. Doctors can treat a number of common health issues like flu and pinkeye. Visit **carefirst.com/needcare** for more information.

Convenience care centers (retail health clinics)

These are typically located inside a pharmacy or retail store (like CVS MinuteClinic or Walgreens Healthcare Clinic) and offer accessible care with extended hours. Visit a convenience care center for help with minor concerns like cold symptoms and ear infections.

Urgent care centers

Urgent care centers (such as Patient First or ExpressCare) have a doctor on staff and are another option when you need care on weekends or after hours.

Emergency room (ER)

An emergency room provides treatment for acute illnesses and trauma. You should call 911 or go straight to the ER if you have a life-threatening injury, illness or emergency. Prior authorization is not needed for emergency room services.

For more information, visit **carefirst.com/needcare.**

*The medical providers mentioned in this document are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.

When you need care

When your PCP isn't available, being familiar with your options will help you locate the most appropriate and cost-effective medical care. The chart below shows how costs* may vary for a sample health plan depending on where you choose to get care.

	Sample cost	Sample symptoms	Available 24/7	Prescriptions?
Video Visit	10% AB	▪ Cough, cold and flu ▪ Pink eye ▪ Ear infection	✔	✔
Convenience Care (e.g., CVS MinuteClinic or Walgreens Healthcare Clinic)	10% AB	▪ Cough, cold and flu ▪ Pink eye ▪ Ear infection	✘	✔
Urgent Care (e.g., Patient First or ExpressCare)	10% AB	▪ Sprains ▪ Cut requiring stitches ▪ Minor burns	✘	✔
Emergency Room	10% AB	▪ Chest pain ▪ Difficulty breathing ▪ Abdominal pain	✔	✔

* The costs in this chart are for illustrative purposes only and may not represent your specific benefits or costs.

To determine your specific benefits and associated costs:

- Log in to *My Account* at **carefirst.com/myaccount**
- Check your Evidence of Coverage or benefit summary
- Ask your benefit administrator, or
- Call Member Services at the telephone number on the back of your member ID card

For more information and frequently asked questions, visit **carefirst.com/needcare**.

Did you know that where you choose to get lab work, X-rays and surgical procedures can have a big impact on your wallet? Typically, services performed in a hospital cost more than non-hospital settings like LabCorp, Advanced Radiology or ambulatory surgery centers.

PLEASE READ: The information provided in this document regarding various care options is meant to be helpful when you are seeking care and is not intended as medical advice. Only a medical provider can offer medical advice. The choice of provider or place to seek medical treatment belongs entirely to you.

SUM3119-1P (8/17)

Health & Wellness

Putting the power of health in your hands

Improving your health just got easier! CareFirst BlueCross BlueShield (CareFirst) has partnered with Sharecare, Inc.* to bring you a new, highly personalized wellness program. Catering to your unique health and wellness goals, our program offers motivating digital resources—accessible anytime—to help you live a healthier life.

Ready to take charge of your health?

Want to find out if your healthy habits are truly making an impact? Take the RealAge® health assessment! In just a few minutes, RealAge will help you determine the physical age of your body versus your calendar age. You'll discover the lifestyle behaviors helping you stay younger or making you age faster and receive insightful recommendations based on your results.

Exclusive features

Our wellness program is full of tailored resources and tools that reflect your own preferences and interests. You get:

- **A personalized health newsfeed:** Receive insights, content and services.
- **Trackers:** Connect your wearable devices to monitor daily habits like sleep, steps, nutrition and more.
- **Challenges:** Having trouble staying motivated? Join a challenge to make achieving your health goals more entertaining.
- **A health profile:** Access your important health data like biometric information, vaccine history, lab results and medications all in one place.

Download the mobile app to access wellness tools and resources whenever and wherever you want.

*Sharecare, Inc. is an independent company that provides health improvement management services to CareFirst members.

Specialized programs

The following programs can help you focus on specific wellness goals.

Health coaching

You may receive a call or email inviting you to participate in health coaching. Coaches are registered nurses and trained professionals who provide one-on-one support to help you reach your wellness goals. If you are contacted, we encourage you to take advantage of this voluntary and confidential program that can help you achieve your best possible health.

Weight management program

If you are age 18 or older, have a body mass index (BMI) of 30 or greater and are looking to lose weight, our weight management program offers a personalized solution for long-term weight loss.

Tobacco cessation program

Quitting smoking and other forms of tobacco can lower your risk for many serious conditions from heart disease and stroke to lung cancer. Our program's expert guidance, support and wealth of tools make quitting easier than you might think.

Financial well-being program

Learn how to take small steps toward big improvements in your financial situation. Whether you want to stop living paycheck to paycheck, get out of debt, or send a child to college, our financial well-being program can help.

Additional offerings

- **Wellness discount program**—Sign up for Blue365 at **carefirst.com/wellnessdiscounts** to receive special offers from top national and local retailers on fitness gear, gym memberships, healthy eating options and more.
- ***Vitality* magazine**—Read our member magazine which includes important plan information at **carefirst.com/vitality**.
- **Health education**—View our health library for more health and well-being information at **carefirst.com/livinghealthy**.

To get started, visit **carefirst.com/sharecare**. You'll need to enter your CareFirst account username and password and complete the one-time registration with Sharecare to link your CareFirst account information. This will help personalize your experience.

Mental Health Support

Well-being for mind and body

Living your best life involves good physical and mental health. Emotional well-being is important at every stage in life, from adolescence through adulthood.

It's common to face some form of mental health challenge during your life. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) are here to help. Our FirstCare℠ team includes specially trained service representatives, registered nurses, clinical social workers and licensed behavioral health specialists who, based on your individual needs, will:

- Help you find the right mental health provider(s) and schedule appointments
- Connect you with a care coordinator who will work with your doctor to create a tailored action plan
- Find support groups and resources to help you stay on track

When mental health difficulties arise for you or a loved one, remember you are not alone. Help is available and feeling better is possible.

CareFirst members have access to specialized services and programs for depression, anxiety, drug or alcohol dependence, eating disorders, and other mental health conditions.

FirstCare℠ is a service mark of CareFirst BlueCross BlueShield.

If you are in crisis, help is available 24/7 at 800-245-7013.

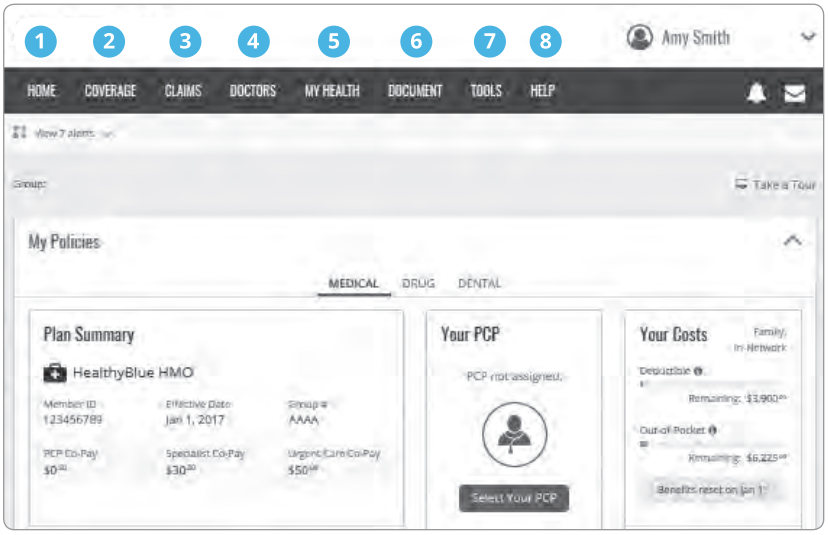
If you or someone close to you needs support or help making an appointment, call our FirstCare team at 800-245-7013, Monday-Friday 8 a.m.–6 p.m. ET. Or for more information, visit **carefirst.com/mentalhealth.**

SUM3223-1P (3/19)

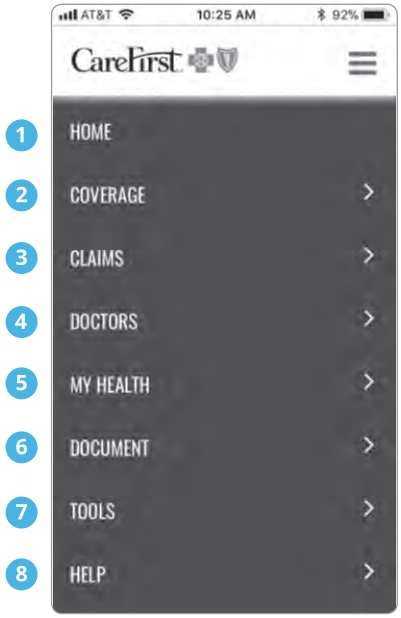
My Account

Online access to your health care information

My Account makes it easier than ever to understand and manage personalized information about your health plan and benefits. Set up an account today! Go to **carefirst.com/myaccount** to create a username and password.



As viewed on a computer.



As viewed on a smartphone.

My Account at a glance

1 Home

- Quickly view plan information including effective date, copays, deductible, out-of-pocket status and recent claims activity
- Manage your personal profile details including password, username and email, or choose to receive materials electronically
- Send a secure message via the *Message Center*
- Check *Alerts* for important notifications

2 Coverage

- Access your plan information—plus, see who is covered
- Update your other health insurance information, if applicable
- View, order or print member ID cards
- Review the status of your health expense account (HSA or FSA)[1]
- Order and refill prescriptions
- View prescription drug claims

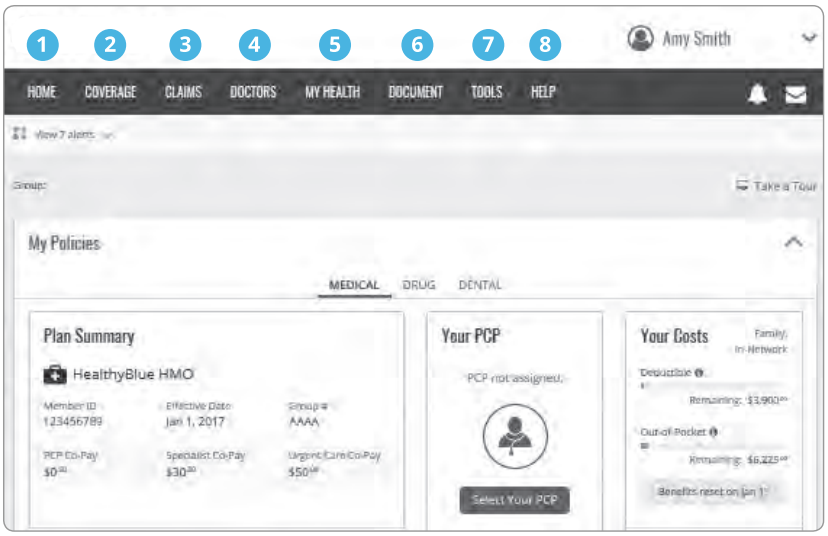
Signing up is easy

Information included on your member ID card will be needed to set up your account.

- Visit carefirst.com/myaccount
- Select *Register Now*
- Create your username and password

[1] Only if offered by your plan.

My Account



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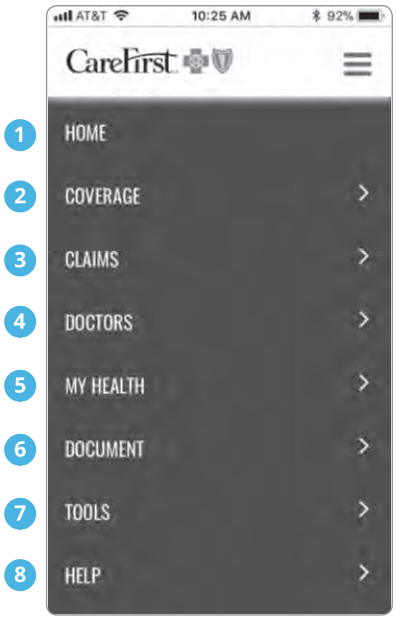

As viewed on a smartphone.

3 Claims

- Check your claims activity, status and history
- Review your Explanation of Benefits (EOBs)
- Track your remaining deductible and out-of-pocket total
- Submit out-of-network claims
- Review your year-end claims summary

4 Doctors

- Find in-network providers and facilities nationwide, including specialists, urgent care centers and labs
- Select or change your primary care provider (PCP)
- Locate nearby pharmacies

5 My Health

- Access health and wellness discounts through Blue365
- Learn about your wellness program options[1]
- Track your Blue Rewards progress[1]

6 Documents

- Look up plan forms and documentation[2]
- Download *Vitality*, your annual member resource guide

7 Tools

- Access the Treatment Cost Estimator to calculate costs for services and procedures[3]
- Use the drug pricing tool to determine prescription costs

8 Help

- Find answers to many frequently asked questions
- Send a secure message or locate important phone numbers

[1] Only if offered by your plan.

[2] Only available when using a computer.

[3] The doctors accessed via this website are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.

BRC6499-1P (2/18)

Medical Benefits Options

Effective for plan year July 1, 2019–June 30, 2020

	Triple Option (available only to out-of-state residents)		
The Benefits	**Level 1 BlueChoice Providers**	**Level 2 BlueCross BlueShield PPO Providers**	**Level 3 Participating and Non-Participating Providers**
DEDUCTIBLE (CONTRACT YEAR)			
	None	None	$500 Individual/$1,000 Family
OUT OF POCKET MAXIMUM (CONTRACT YEAR)			
Medical	$2,000 Individual/$4,000 Family		$4,000 Individual/$8,000 Family
Prescription Drug	$4,600 Individual/$9,200 Family		
HOSPITALIZATION			
Inpatient Facility	10% AB	10% AB	30% AB after deductible
Inpatient Physician	10% AB	10% AB	30% AB after deductible
Outpatient Facility	10% AB	10% AB	30% AB after deductible
Outpatient Physician	10% AB	10% AB	30% AB after deductible
MATERNITY CARE			
Delivery and Facility	10% AB	10% AB	30% AB after deductible
Infertility Services: Artificial Insemination (AI) and In Vitro Fertilization (IVF) (IVF limited to 3 attempts/live birth up to a lifetime maximum of $100,000)	10% AB	10% AB	30% AB after deductible
EMERGENCY CARE			
Hospital Emergency Room Facility	10% AB	10% AB	10% AB, no deductible
Hospital Emergency Room Physician	10% AB	10% AB	10% AB, no deductible
Urgent Care Center	10% AB	10% AB	30% AB after deductible
MEDICAL SERVICES			
Office Visits for Illness	10% AB	10% AB	30% AB after deductible
Diagnostic X-rays	10% AB	10% AB	30% AB after deductible
Radiation & Chemotherapy	10% AB	10% AB	30% AB after deductible
Laboratory Test	10% AB (Labcorp only)	10% AB	30% AB after deductible
Allergy Testing	10% AB	10% AB	30% AB after deductible
Allergy Treatment/Injections	10% AB	10% AB	30% AB after deductible
Physical, Speech and Occupational Therapy (limited to 100 visits/benefit period combined PT/OT/ST)	10% AB	10% AB	30% AB after deductible
Chiropractic Services (limited to 20 visits/condition/ benefit period)	10% AB	10% AB	30% AB after deductible
Acupuncture	10% AB	10% AB	30% AB after deductible

AB = Allowed Benefit

	BlueChoice Opt-Out Plus	
The Benefits	**In-Network**	**Out-of-Network**
DEDUCTIBLE (CONTRACT YEAR)		
	None	$300 Individual/$600 Family
OUT OF POCKET MAXIMUM (CONTRACT YEAR)		
Medical	$2,000 Individual/$4,000 Family	$4,000 Individual/$8,000 Family
Prescription Drug	$4,600 Individual/$9,200 Family	
HOSPITALIZATION		
Inpatient Facility	10% AB	30% AB after deductible
Inpatient Physician	10% AB	30% AB after deductible
Outpatient Facility	10% AB	30% AB after deductible
Outpatient Physician	10% AB	30% AB after deductible
MATERNITY CARE		
Delivery and Facility	10% AB	30% AB after deductible
Infertility Services: Artificial Insemination (AI) and In Vitro Fertilization (IVF) (IVF limited to 3 attempts/live birth up to a lifetime maximum of $100,000)	10% AB	30% AB after deductible
EMERGENCY CARE		
Hospital Emergency Room Facility	10% AB	10% AB, no deductible
Hospital Emergency Room Physician	10% AB	10% AB, no deductible
Urgent Care Center	10% AB	30% AB after deductible
MEDICAL SERVICES		
Office Visits for Illness	10% AB	30% AB after deductible
Diagnostic X-rays	10% AB	30% AB after deductible
Radiation & Chemotherapy	10% AB	30% AB after deductible
Laboratory Test	10% AB (Labcorp only)	30% AB after deductible
Allergy Testing	10% AB	30% AB after deductible
Allergy Treatment/Injections	10% AB	30% AB after deductible
Physical, Speech and Occupational Therapy (limited to 100 visits/benefit period combined PT/OT/ST)	10% AB	30% AB after deductible
Chiropractic Services (limited to 20 visits/condition/ benefit period)	10% AB	30% AB after deductible
Acupuncture	10% AB	30% AB after deductible

AB = Allowed Benefit

Medical Benefits Options

	Triple Option (available only to out-of-state residents)		
The Benefits	**Level 1 BlueChoice Providers**	**Level 2 BlueCross BlueShield PPO Providers**	**Level 3 Participating and Non-Participating Providers**
PREVENTIVE CARE			
Well Baby & Child Care	No Charge	No Charge	30% AB after deductible
Immunization	No Charge	No Charge	30% AB after deductible
Annual Physical Exam	No Charge	No Charge	30% AB after deductible
Annual Gynecological Exam	No Charge	No Charge	30% AB after deductible
Eye Exams	$10 copay at Davis designated vision center (one per plan year)		
Eye Glasses	Discounts available through Davis Vision		
SPECIAL SERVICES			
Hearing Aid Evaluation Test	10% AB	10% AB	30% AB after deductible
Basic Hearing Aid (one every 36 months)	10% AB	10% AB	30% AB after deductible
Home Health Care Visits (limited to 90 days/benefit period; 40 Home Health Aid visits/per benefit period)	10% AB	10% AB	30% AB after deductible
Ambulance	10% AB	10% AB	10% AB, no deductible
Habilitative Services (up to age 19; must be preauthorized after initial visit)	10% AB	10% AB	30% AB after deductible
MENTAL HEALTH/SUBSTANCE ABUSE			
Inpatient Care	10% AB	10% AB	30% AB after deductible
Outpatient Care	10% AB	10% AB	30% AB after deductible
PRESCRIPTION DRUG PROGRAM			
Prescription Drugs	$10 copay—Generic drugs $35 copay—Preferred Brand drugs $65 copay—Non-preferred Brand drugs Maintenance drugs—2 copays (Mail or Retail)		

AB = Allowed Benefit

Medical Benefits Options

	BlueChoice Opt-Out Plus	
The Benefits	**In-Network**	**Out-of-Network**
PREVENTIVE CARE		
Well Baby & Child Care	No Charge	30% AB after deductible
Immunization	No Charge	30% AB after deductible
Annual Physical Exam	No Charge	30% AB after deductible
Annual Gynecological Exam	No Charge	30% AB after deductible
Eye Exams	$10 copay at Davis designated vision center (one per plan year)	
Eye Glasses	Discounts available through Davis Vision	
SPECIAL SERVICES		
Hearing Aid Evaluation Test	10% AB	30% AB after deductible
Basic Hearing Aid (one every 36 months)	10% AB	30% AB after deductible
Home Health Care Visits (limited to 90 days/benefit period; 40 Home Health Aid visits/per benefit period)	10% AB	30% AB after deductible
Ambulance	10% AB	10% AB, no deductible
Habilitative Services (up to age 19; must be preauthorized after initial visit)	10% AB	30% AB after deductible
MENTAL HEALTH/SUBSTANCE ABUSE		
Inpatient Care	10% AB	30% AB after deductible
Outpatient Care	10% AB	30% AB after deductible
PRESCRIPTION DRUG PROGRAM		
Prescription Drugs	$10 copay—Generic drugs $35 copay—Preferred Brand drugs $65 copay—Non-preferred Brand drugs Maintenance drugs—2 copays (Mail or Retail)	

AB = Allowed Benefit

Your Medicare Supplemental Plan

Your protection against illness and high medical costs

Times have changed, and so have your needs. Even though you have Medicare, you still need additional health insurance to help cover your medical expenses. That's why Harford County Government has selected the CareFirst BlueCross BlueShield Medicare Supplemental Plan for you. When you use the providers who participate with Medicare, you will have little to pay for Medicare-covered services. That way, you can just concentrate on feeling better.

Using your benefit summary

This benefit summary will show you how to use the Medicare Supplemental Plan. As you read through it, you see terms such as deductible and approved amount. The definitions for these terms can be found in the Definitions Section of this book. They will help you understand how your plan can save you money and make your Medicare coverage even better than before.

This benefit summary will also tell you the following:

- What the Medicare Supplemental Plan is and how it works.
- What Medicare does and doesn't cover.
- When you'll need to file claims, and how to file them.
- How to get the most from your health care plans.
- What your Medicare Supplemental benefits are.

If you have any questions, just call CareFirst BlueCross BlueShield's Customer Service Department at (800) 628-8549. You can call between 8:00 a.m. and 10:00 p.m., Monday through Friday and 8:00 a.m. and 1:00 p.m., Saturday. A customer service representative will be happy to help you.

What your plan is and how it works

What does the Medicare Supplemental Plan cover?

First, it covers your inpatient Medicare deductible and coinsurance, costs associated with emergency care, outpatient surgery and diagnostic services. Second, CareFirst BlueCross BlueShield will pay 80% of the difference between what Medicare pays and the Medicare approved amount (when you visit Medicare participating providers) or limiting charge (when you visit Medicare non-participating providers) for Major Medical services such as office visits and durable medical equipment.

How does the Medicare Supplemental Plan work?

Your Medicare coverage is always primary. That means that Medicare always pays first for Medicare-covered services. Your Medicare Supplemental Plan is your secondary plan. It provides benefits for some charges and services not covered by Medicare.

When you use a Medicare participating provider for medical services, you will have less to pay for Medicare - covered services because these providers have agreed to accept the Medicare approved amount for their services, commonly referred to as "accepting assignment."

Medicare non-participating providers do not always accept the Medicare approved amount. You will pay more for your care when you use Medicare non-participating providers.

Sometimes Medicare non-participating providers will agree to accept the Medicare approved amount for some services. Whenever they do, you will have less to pay for covered services. Please refer to questions 4 & 5 for examples.

How can I save money with my Medicare Supplemental Plan?

Your Medicare Supplemental Plan pays all of your up-front Medicare Part A deductibles and coinsurance amounts, regardless if you see a Medicare participating or Medicare non-participating provider.

In addition, your Medicare Supplemental Plan covers the Medicare Part B deductible for most services. In these cases, you will not have to pay the deductible, even if you see a Medicare participating or Medicare non-participating provider.

Why is it better to use Medicare participating providers?

When you use Medicare participating providers for Medicare and Major Medical covered services, you save money.

Here's an example of a Major Medical service:

Provider's charge	$50.00
Medicare approved amount	$28.00
Medicare pays 80% of $28 approved amount (after Part B deductible)	$22.40
Balance	**$5.60**
CareFirst pays 80% of $5.60 balance	$4.48
You pay remaining 20% coinsurance	**$1.12**

How much will I pay if I use Medicare non-participating providers?

Medicare non-participating providers can charge you the difference between the Medicare approved amount and the Medicare limiting balance. The difference is usually 15% more than the approved amount.

For example, a Medicare participating provider charges the approved amount for a service, say $28. A Medicare non-participating provider charges you up to the limiting charge, which would be about $32.20.

Here's an example of a Major Medical service:

Provider's charge	$50.00
Medicare approved amount	$28.00
Medicare limiting charge (15% greater than Medicare approved amount)	$32.20
Medicare pays 80% of $28 approved amount (after Part B deductible)	$22.40
Balance	**$9.80**
CareFirst pays 80% of $5.60	$4.48
You pay remaining balance up to Medicare limiting charge	**$5.32**

CareFirst's allowed benefit for services covered by Medicare and CareFirst will not exceed the Medicare approved amount/Medicare limiting charge.

How can I find out if a doctor is participating with Medicare?

There are two ways you can check on a doctor's participation with Medicare:

- Check the Medicare MedPar Directory (you can receive your own copy by calling Medicare).
- Call the provider directly.

What Medicare does and doesn't cover

What does Medicare cover?

Medicare has two parts, A and B. Medicare Part A (hospital insurance) partially pays for medically necessary:

- Inpatient hospital facility charges.
- Care in a skilled nursing facility after a hospital stay.
- Home health care provided by a Medicare – participating home health agency.
- Hospice care for the terminally ill.

Medicare Part B (medical services insurance) partially pays for medically necessary:

- Physician's services.
- Outpatient hospital services.
- Home health visits.
- Physical and speech therapy.
- Services and supplies covered by Medicare, such as x-rays and durable medical equipment.

What isn't covered by Medicare?

Medicare does not pay the full cost of all covered services. Medicare requires that you pay a share of the costs in the form of deductibles and coinsurance/copays.

What you'll need to file claims

You never have to submit a claim to Medicare. By law all providers must file these claims for you. And that applies to non-participating providers as well as participating providers.

If I receive care in Maryland, will I have to file any claims to CareFirst?

You will not have to file any claims with CareFirst for covered services if you receive the services in Maryland, Washington D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. While you may be asked to fill out claim forms for the provider, you will not have to submit the claims yourself.

CareFirst electronically receives claims from Medicare for covered services received in Maryland, Washington D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. That means that your claims automatically come to us from Medicare when you give your CareFirst membership number to your provider at the time you receive care.

Make sure that you always give your CareFirst membership number to your provider when you give your Medicare membership number. Without your CareFirst number, Medicare won't know to forward your claim information to us. You will then have to file your own claim.

Will I have to file any claims to CareFirst if I receive care outside of the states listed above?

Yes, your providers will file your Medicare claims for you. That's the law. But you will have to file claims with CareFirst to get benefits from your Traditional Medicare Supplemental Plan.

Here's what you should do. After Medicare has paid its share, you will receive an "Explanation of Medicare Benefits" (EOMB). Make copies of this form and of your bills for each claim. Do not send the original EOMB and medical bills. Keep the originals in your files. Claims rarely get lost, but if that should happen, you can resubmit your claim if you have kept the originals.

Send a copy of the EOMB, your bills and a completed claim form to the following address:

CareFirst Blue Cross Blue Shield
Mail Administrator
P.O. Box 14114
Lexington, KY 40512

What if I need a claim form or help submitting a claim?

Just call your CareFirst customer service representative. The numbers to call are (410) 581-3539 or (800) 342-7287. You can also call these numbers if you want to find out if your claim has been received.

Is there a deadline for filing claims?

Yes, we must receive your claims by December 31 following the year in which you receive medical care.

For example, if you received care in January of 2018, you should file your claim no later than December 31, 2019.

What happens if my claim arrives after the deadline?

Your claim will not be covered, and you will not receive payment. So be sure to file your claim right away.

Getting the most from your health care plan

To make sure that you make the most of your benefits and pay the least for care, follow these simple guidelines:

- Always find out if a provider is participating (accepts the Medicare approved amount) or non-participating (does not accept the Medicare approved amount) before you receive care.
- Avoid additional out-of-pocket expenses by using Medicare participating providers when you need Medicare-covered services.
- Always give your Medicare membership number and your CareFirst membership number when you receive care.
- If you need to file a claim, file right away so that you don't miss the filing deadline.

Your retail prescription drug plan

Your medical ID card is also your Rx card and should be given to the pharmacy each time you fill a prescription. You will pay a 20% copayment up front for your prescriptions. We encourage you to shop around for the best price to reduce your out-of-pocket expense. Pharmacy claims cannot be submitted on a Major Medical claim form for reimbursement.

Mail service prescription drug program sponsored by CVS

A mail service prescription drug program is a special added feature to your Medicare Supplemental Plan. For those who regularly take maintenance medications, this service provides a convenient and inexpensive way for you to order these medications and have them delivered to your home.

You can order up to a 90-day supply of medication for the required copayment of $10. You must send the $10 copayment with your prescription to CVS. The copayment will not be reimbursed through your medical benefits.

Medications are delivered to your home postage paid via UPS or First Class U.S. Mail.

If you have any questions regarding this prescription service, call the CVS toll-free patient services telephone number, Monday through Friday at (800) 241-3371.

Harford County Medicare Supplemental Plan

Summary of Benefits

Benefits	Other Payments Made		Member Payment	
	Remaining Costs after Medicare Payment	CareFirst Plan Payment	Provider Accepting Medicare Assignment	Provider Not Accepting Medicare Assignment
FACILITY				
Inpatient Hospital Days 1–60 Days 61–90 Lifetime reserve	Part A initial deductible $1,364 $341 per day $682 per day	 $1,364 $341 per day $682 per day	No member payment No member payment No member payment No member payment	No member payment No member payment No member payment No member payment
Skilled Nursing Facility Days 1–20 Days 21–100	 None $170.50 per day	 None $170.50 per day	 No member payment No member payment	 No member payment No member payment
Home Health	None	None		
Hospice Care	Medicare pays most charges. Remaining costs include drug copayment and limited cost for respite care.	Remaining cost	No member payment	No member payment
PHYSICIAN SERVICES				
Inpatient	20% of Medicare's approved amount and Part B deductible if accepting assignment	100% up to CareFirst allowed benefit	No member payment	No member payment
Emergency	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Surgery	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit	No member payment	No member payment
Laboratory Services	100%	None	No member payments	N/A
Radiology Services (Inpatient)	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit	No member payment	No member payment
Radiology Services (Outpatient or Office)	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Office Visit	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Office Therapy				
Radiation/ Chemotherapy	20% of Medicare's approved amount	100% up to CareFirst allowed benefit	No member payment	No member payment
Physical Therapy	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge

The Medicare deductibles and coinsurance amounts shown are based on 2018 figures. Your benefits will automatically adjust to meet any amounts that change in 2019.

CareFirst's allowed benefit for services covered by Medicare and CareFirst will not exceed the Medicare approved amount/Medicare limiting charge.

Benefits	Other Payments Made		Member Payment	
	Remaining Costs after Medicare Payment	CareFirst Plan Payment	Provider Accepting Medicare Assignment	Provider Not Accepting Medicare Assignment
OTHER SERVICES				
Ambulance Services	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Durable Medical Equipment	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Prosthetic Appliances	20% of Medicare's approved amount deductible	100% up to allowed benefit	No member payment	No member payment
Whole Blood (In full—Part A, 3 pint deductible—Part B)	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Medical Supplies	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Hearing Benefits (once every 36 months)	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount	Balance up to Medicare's limiting charge
Physical Exam		100% of allowed benefit	No member payment	No member payment
Mammograms	Pays for one every 12 months	Difference up to Medicare's approved amount or 100% of CareFirst allowed benefit when not covered by Medicare	No member payment	No member payment when Medicare approved. Difference between CareFirst allowed benefit and provider's charge when not Medicare approved.
Prostate Cancer Screening	Pays for one every 12 months	Difference up to Medicare's approved amount or 100% of CareFirst allowed benefit when not covered by Medicare	No member payment	No member payment when Medicare approved. Difference between CareFirst allowed benefit and provider's charge when not Medicare approved.

Medicare does not place a limiting charge on durable medical equipment, therefore the CareFirst allowed benefit will prevail.

If Medicare benefits are exhausted, or service is not covered by Medicare, CareFirst Medicare Supplemental Plan benefits may be provided.

Blue Cross and Blue Shield benefits for inpatient hospital services are provided for 90 days per inpatient stay with a 60-day renewal interval. That is, an inpatient stay will be one stay if discharge date and readmission date are not separated by at least 60 days.

Reimbursement under Major Medical is subject to an annual deductible of $100 per individual. After your deductible is met, payment is made at 80% of allowed benefit and you pay the coinsurance of 20%.

Words You Need to Know

Medicare Supplemental

Approved Amount

The amount that Medicare allows participating providers to be paid for Medicare—covered services. Payments are made according to the Medicare fee schedule (see page 36).

Participating providers agree to accept the approved amount as payment in full for covered services. Non-participating providers can charge you more than this amount for your care (see limiting charge). The "approved amount" also may be called the "allowed amount" or "assignment".

Coinsurance

Some services require that you pay a percentage of the costs for your medical care. For example, under Medicare Part B, you pay 20% and Medicare pays 80%.

Some services require that you pay a set-dollar amount for your care. For example, under Medicare Part A, you must pay a set amount per day for inpatient hospital care after you've been hospitalized for over 60 days.

Your Traditional Medicare Supplemental Plan pays the Part A coinsurance for you.

Deductibles

Some services require that you pay a deductible before Medicare begins to pay. For example, under Medicare Part A, you must pay the first $1,100 of your hospital bill. And under Medicare Part B, you must pay the $200 deductible for services. Then Medicare begins to pay its share.

Limiting Charge

Some providers do not accept the Medicare approved amount as payment in full for Medicare – covered services. To protect you from high charges for these services, Medicare limits the amount that these non-participating providers can bill you.

The limiting charge does not apply to any of the Traditional Medicare. Supplemental Plan benefits that Medicare does not cover.

Medicare Fee Schedule

In general, payments for services are made according to the standard Medicare – approved fee schedule.

Medicare Participating Providers

Physicians and suppliers who agree to always accept the Medicare approved amount as payment in full for services. (You still pay deductibles and coinsurance.) Medicare participating providers can charge you full price for services that Medicare does not cover.

Medicare Non-Participating Providers

Other physicians and suppliers who do not agree to always accept the Medicare approved amount as payment in full for services. Medicare limits the amount that non-participating providers can charge for Medicare – covered services. If you choose to see a non-participating provider, you must pay any difference between the limiting charge and the Medicare approved amount.

Provider

Any licensed doctor, nurse or professional. A provider may also be a health care facility, such as a hospital, laboratory or clinic.

PPO Plus Premier Dental

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Plan Benefit Highlights for: Harford County Governmental Entities
Group No: 00430 – 00001, 00002 & 09999

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	$25 per person / $75 per family each plan year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	$1,500 per person each plan year			
D & P counts toward maximum?	No			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings and posterior composites	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	50 %
Prosthodontics Bridges, dentures and implants	50 %	50 %
Orthodontic Benefits Dependent children to age 20	50 %	50 %
Orthodontic Maximums	$1,000 Lifetime	$1,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania	Customer Service	Claims Address
One Delta Drive Mechanicsburg, PA 17055	800-932-0783	P.O. Box 2105 Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

HLT_PPO_2COL_DDP (Rev. 03/26/2018)

PPO Dental

Plan Benefit Highlights for: Harford County Governmental Entities
Group No: 00430 – 01001, 01002 & 19999

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	**Delta Dental PPO dentists:** $25 per person / $75 per family each plan year **Non-Delta Dental PPO dentists:** $75 per person / $150 per family each plan year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	$1,500 per person each plan year			
D & P counts toward maximum?	No			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	75 %
Basic Services Fillings and posterior composites	80 %	60 %
Endodontics (root canals) Covered Under Basic Services	80 %	60 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	60 %
Oral Surgery Covered Under Basic Services	80 %	60 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	35 %
Prosthodontics Bridges, dentures and implants	50 %	35 %
Orthodontic Benefits Dependent children to age 20	50 %	35 %
Orthodontic Maximums	$1,000 Lifetime	$1,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, PPO contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

HLT_PPO_2COL_DDP (Rev. 03/26/2018)

Select Vision Program

Making vision care more affordable

Vision is one of our most valued assets. Everyone should take precautions to protect this priceless gift. Some vision problems, such as glaucoma, can only be detected through regular, professional vision exams. Without proper care, these problems can gradually grow worse.

Vision benefits: An affordable option

Vision care is one of the least expensive health care benefits you can purchase. It is also one of the first optional benefits chosen by employees when it is offered.

Select Vision helps you commit to routine eye exams and preventive care that help detect small problems before they become serious and costly. Select Vision provides benefits for:

- Comprehensive vision examinations
- Lenses and frames or contact lenses

Need more information? Please visit **www.carefirst.com.**

A name you can trust

CareFirst BlueCross BlueShield is one of the largest health insurers in Maryland. You will be pleased that you have chosen CareFirst BlueCross BlueShield to provide such an important and valuable benefit program.

Freedom of choice

With Select Vision you can choose any licensed vision care provider—in Maryland or out of state. You have complete freedom to choose your own ophthalmologists, optometrists, and opticians. You may choose to see your current provider, a provider convenient to work or home, or take the recommendations of others.

Easy to use

You simply show your CareFirst BlueCross BlueShield membership card to participating providers at the time of service. The participating provider will bill us and we pay them directly for their services. You don't have any paperwork or claims to file.

If you choose a non-participating provider for your care, you must pay the provider. We will reimburse you up to the limits of your vision plan.

CUT5733-1P (8/17)

Participating providers save you money

Participating providers agree to accept our reimbursement as payment in full for routine eye examinations.

You can identify participating providers by the distinctive CareFirst BlueCross BlueShield Participating Provider plaque in their offices. If you don't see the plaque, you can ask the provider if he or she participates with CareFirst BlueCross BlueShield before you receive care. You may also call CareFirst BlueCross BlueShield member services to find out if a provider participates.

Non-participating providers

You can also receive vision exams, frames and lenses, or contact lenses from non-participating providers. You must pay these providers for these services and submit any bills or receipts to CareFirst BlueCross BlueShield. We will directly reimburse you up to the allowed benefit or scheduled amount. You are responsible for any difference between our allowed benefit and the billed charges.

What is not covered

- Sunglasses (lenses darker than tint 2), even if prescribed.
- Replacement, within the same benefit period, of lost or damaged frames or lenses (including contacts) for which benefits were provided.
- Exams or materials furnished after the member's coverage is terminated (unless lenses and frames or contact lenses are ordered prior to the termination date and received within 30 days after the date of the order).
- Separate exam for contact lens fitting.

EYE EXAMINATIONS	100% of the Allowed Benefit		
GLASSES	**LENSES (per pair)**	**FRAMES (per pair)**	**MAXIMUM ALLOWANCE**
Single Vision	$41.50	$29.50	$71.00
Bifocal	$67.00	$29.50	$96.50
Trifocal	$89.50	$29.50	$119.00
Double Bifocal	$100.50	$29.50	$130.00
Cataract (Aphakic)	$156.50	$29.50	$186.00
CONTACT LENSES (PER PAIR)*			
Single Vision (not medically required)	$71.00		
Bifocal (not medically required)	$96.50		
Medically Required (following cataract surgery or when vision acuity is correctable to at least 20/70 in the better eye only by use of contact lenses)	$221.00		

* Fashion contact lenses, which are not corrective, are not included in the schedule of benefits.

Not all services are covered by your benefits contract.

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

CUT5733-1P (8/17)

Definitions

These definitions have been developed to help you become familiar with some of the terms in this manual.

Allowed Benefit

The criteria CareFirst BlueCross BlueShield uses to determine payments to your physician. It is based upon the Resource Based Relative Value Unit System. This system takes 3 factors into consideration; work value (amount of skill/time/effort required for service), practice expense (cost of overhead expenses), and the liability/malpractice expense for covered services.

Card (Identification/Membership)

Identification or membership card for medical/pharmacy coverage and/or dental. The card identifies the employee, types of elected coverage, type of membership and the effective date of coverage.

Coinsurance

A cost-sharing requirement under your CareFirst BlueCross BlueShield policy which requires you to assume a percentage of the costs of covered services.

Copay

Cost sharing in which you pay a flat amount per service. Unlike coinsurance the amount does not vary as a percentage of the cost of the service.

Deductible

Amount of expense you must incur before CareFirst BlueCross BlueShield will assume any liability for all or part of the remaining cost of covered services.

Eligibility

State of fulfilling requirements for coverage.

In-network Provider

A preferred provider within a Preferred Provider Organization.

Medical Emergency

The sudden and unexpected onset of a serious illness or condition which requires necessary, immediate medical care.

Non-Participating Provider

A physician or other provider who has not signed an agreement with the CareFirst BlueCross BlueShield plan to accept the Allowed Benefit as payment in full.

Out-of-Network Provider

A provider that is not part of the PPO network

Out-of-pocket

The deductible copayment plus any coinsurance amount that the subscriber pays; once this has been met the policy will normally pay at 100% of the Allowed Benefit for most covered services.

Participating Provider

Individual physicians, hospitals and professional health care providers who have a contract with CareFirst BlueCross BlueShield and/or CareFirst BlueChoice, Inc. to provide services to its members at a discounted rate and to be paid directly for covered services.

Medical Plan Year

The Plan Year is twelve months July 1–June 30.

Dental Plan Year

The Plan Year is twelve months July 1–June 30.

Professional Component

That portion of a charge for x-ray or laboratory services performed in a hospital which is allocated to a physician as his professional fee.

Provider

An individual or institution that provides medical care.

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 7/12/18)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	**civilrightscoordinator@carefirst.com**
Telephone Number	410-528-7820
Fax Number	410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Notice of Nondiscrimination and Availability of Language Assistance Services

Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 *and wait through the dialogue until prompted to push* 0. *When an agent answers, state the language you need and you will be connected to an interpreter.*

አማርኛ (Amharic) ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ አነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ አገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtétíléko: Àkíyèsí yìí ní ìwífún nípa ìṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò títí a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

Notice of Nondiscrimination and Availability of Language Assistance Services

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bàsɔ́ɔ̀-wùdù (Bassa) Tò Đùǔ Cáo! Bɔ̌ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fûà-fǔá-tìĭn nyɛɛ jè dyí. Bɔ̌ nìà kɛ ɓéɖé wé jéé ɓě ɓɛ́ m̀ ké ɖɛ wa mó m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá-kpá m̀ móɛɛ dyé ɖé nì ɓíɖí-wùdù mú ɓɛ́ m̀ ké se wíɖí ɖò péè. Kpooɔ̀ nyɔ ɓě mɛ ɖá fǔùn-nɔ̀ɓà nìà ɖé waà I.D. káàɔ̀ ɖeín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ ɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔà 0 kɛɛ dyi pàɖàìn hwè. Ɔ jǔ ké nyɔ ɖò dyi m̀ gɔ̃ jǔĭn, po wuɖu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɖò mu ɓó nììn ɓɛ ɔ ké nì wuɖuɔ̀ mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ :یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید.
اعضا باید با شماره درج شده در پشت کارت شناسایی‌شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه :يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة .يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة .ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم .يمكن للآخرين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم 0. عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

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Igbo (Igbo) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad *(Navajo)* Ge': Díí bee ił hane'ígíí bii' dahólǫ bee éédahózin béeso ách'ą́ąh naanil nik'ist'i'ígíí bá. Bii' dahólǫ́ǫ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyíįlígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'įįh. Bee ná ahóót'i' díí bee ił hane' dóó nikáádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédęę' bikáá' bich'į' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį ádóó éí bikéé'dóó naasbąąs bił adidiilchił. Ákáa'ánidaalwó'ígíí neidiitą́ągo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.

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